Office of the Inspector General

A PERFORMANCE AUDIT OF KHPA'S MEDICAID PHARMACY PROGRAM

Does KHPA's Pharmacy Program Have Effective Controls to Prevent Paying Improper Pharmacy Claims?

A Report to the Kansas Health Policy Authority Board

November 2010

11PA01

OFFICE OF THE INSPECTOR GENERAL
KANSAS HEALTH POLICY AUTHORITY

The Kansas Health Policy Authority (KHPA) Office of Inspector General (OIG) was created by the 2007 Kansas Legislature as part of a much larger health reform bill, commonly referred to as Senate Bill 11. This creation of an independent oversight body, with the responsibility to review and investigate KHPA's performance in delivering health services, was a significant step in reforming public health care in Kansas.

The KHPA OIG, whose enabling statute is K.S.A. 75-7427, is the first statutorily created Office of Inspector General in Kansas. Its mission is:

- To provide increased accountability and integrity in KHPA programs and operations;
- To help improve KHPA programs and operations; and
- To identify and deter fraud, waste, abuse and illegal acts in the State Medicaid Program, the MediKan Program and the State Children's Health Insurance Program.

To fulfill its mission, the KHPA OIG conducts:

- Investigations of fraud, waste, abuse, and illegal acts by KHPA or its agents, employees, vendors, contractors, consumers, clients, health care providers or other providers.
- Audits of the KHPA, its employees, contractors, vendors and health care providers.
- Reviews, which may also be called inspections or evaluations.

The KHPA OIG conducts its audits in accordance with applicable government auditing standards set forth by the U.S. Government Accountability Office and its reviews and investigations in accordance with the Quality Standards for Investigations, Inspections, Evaluations, and Reviews of the Association of Inspectors General.

As required by K.S.A. 75-7427, the KHPA OIG will report findings of fraud, waste, abuse or illegal acts to KHPA and also refer those findings to the Attorney General.

The current Inspector General, Nicholas M. Kramer, was appointed by the KHPA Board in September 2009. His professional certifications include Certified Inspector General, Certified Public Accountant, Certified Internal Auditor, and Certified Information Systems Auditor. Other members of the team are: Felany Opiso-Williams, Auditor; Stephen Mhere, Data Auditor and Kimberly Epps, Administrative Specialist.

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Executive Summary

The purpose of this audit was to evaluate KHPA's system of controls designed to prevent improper pharmacy payments.

There are a number of inherent risks involved with the prescription drug program. A key risk is that individuals could submit claims that exceed program limitations or are fictitious, improper, unsubstantiated, or simply in error. KHPA must maintain a sound system of controls that identifies these invalid claims, to ensure that Medicaid funds are only expended for legitimate prescription drug claims.

Other states have experienced problems when Medicaid beneficiaries and others attempted to acquire excessive quantities of certain drugs. Beneficiaries may try to acquire excessive amounts of drugs that are not medically necessary to satisfy an addiction, for recreational use, or to resell the drugs "on the street." This type of activity is included in CMS' Medicaid Program Integrity definition of "abuse."

KHPA has installed a system of controls designed to authenticate claims, contain costs, and help ensure the safety of drug recipients. Based on our understanding and assessment of the controls in place for the risks we targeted, and because we found only a small percentage of claims paid that should not have been paid, it is the opinion of the Office of Inspector General that KHPA's system provides reasonable control against these risks.

However, no system is completely impervious to fraud and abuse. Resources available for controls are finite. The experiences of other states, where fraud perpetrators have exploited control vulnerabilities, remind us of the importance of maintaining vigilance against potential threats. For this reason, the OIG is providing recommendations in this report to help insure that minor control deficiencies do not become major problems.

To be a legitimate prescription drug claim:

- The beneficiary must be enrolled in Kansas Medicaid and authenticated.
- The prescriber must be licensed to practice and authorized to prescribe the drug.
- The pharmacy must be licensed by the Kansas State Board of Pharmacy.
- The prescription must not exceed any applicable dosage limits.

KHPA has put effective controls in place related to patient safety and drug abuse including dosage limitations for certain controlled substances, computer exception reports that identify possible doctor or pharmacy hopping, and prior authorization and lock-in programs to control risky patient behaviors.

OIG staff employed computer assisted audit techniques in an attempt to find instances where KHPA paid for claims that it should have denied. The most troublesome problem identified is the difficulty in verifying the prescriber of prescription drugs. Verifying the prescriber's identity and authority to prescribe is not only a legal requirement; it is a key safeguard against fraudulent and abusive prescription claims.

KHPA implemented a change in practice that improved verification of the prescriber in 2008. Prior to April 1, 2008, KHPA did not have an edit in place that would deny the claim if it did not include the prescriber identifier. So, from 2007 (the beginning of our audit period) through April 1, 2008, KHPA paid 33,348 claims totaling almost $3 million where it did not verify that the prescriber was legitimate. Since May 2008, KHPA has captured the prescriber NPI to provide improved assurance of the legitimacy of the prescription. Unfortunately, this requirement does not go far enough in ensuring that all prescriptions that KHPA pays were ordered by prescribers who are currently licensed and authorized to prescribe.

Although many of KHPA's prescription drug payment controls are functioning as intended, the OIG identified several controls, especially those related to authenticating the prescriber of drug claims that could be improved.

- We identified 3,575 claims, totaling about $ 210,000, where KHPA paid for prescriptions that were ordered by prescribers whose license was either inactive or suspended by their respective Kansas licensing board at the time the prescription was written. A good portion of these may have been legitimate, because the prescriber may have relocated to and obtained licensure in another state, while still treating Kansas Medicaid patients. KHPA paid these claims without knowing whether the prescribers were appropriately licensed.
- KHPA does not have an effective process for authenticating out-of-state or other non-KMAP-enrolled prescribers. Our system of edits requires that we capture the NPI (National Provider Identifier) number and subject it to a numerical validation test (the Luhn formula). Although this test provides assurance that the number is a valid number; it may not be ***this prescriber's*** number.

With the exception of prescriptions ordered by unauthorized prescribers, we identified only a small number of paid claims that should not have been paid.

- KHPA paid two pharmacies for prescriptions they filled after the dates established for KMAP termination. Upon request from one of the pharmacies, KHPA officials back-dated the termination date, resulting in claims for several months, amounting to about $242,000, appearing to be improperly paid. The other pharmacy submitted claims for prescriptions filled after its termination date, resulting in $11,000 in questionable claims.
- KHPA paid for 66 duplicate claims, amounting to an overpayment of about $1,785. This indicates that edits designed to catch duplicate claims do not always work.

- KHPA paid claims for prescription drugs for 13 beneficiaries that were dispensed after the beneficiary had died.
- KHPA paid for 101 prescriptions that were dispensed over one year after three prescribers had died.

These are isolated instances which represent a very small proportion of prescription drug claims processed. We point out these instances as examples of small imperfections in the control system. Using these minor problems as relatively inexpensive lessons, KHPA can make corrections to its control system that should avert larger problems that could arise in the future.

The OIG proposed 10 recommendations for improving control processes. These include:

- Changing system edits to ensure that deceased prescribers are promptly identified in the MMIS so that no one else could acquire drugs or receive payments by fraudulently submitting a deceased prescriber's identification number. This will require comparing the prescription date to the prescriber's death date.
- Ensuring effective coordination with licensing boards so that inactive or suspended prescribers and unlicensed pharmacies are promptly identified and deactivated in the MMIS.
- Utilizing information from national registries to authenticate non-Kansas Medicaid providers who prescribe drugs for Kansas patients.
- Reconsidering KHPA's policy for approving claims for prescription refills after the doctor-patient relationship has been severed. The Board of Pharmacy issued an advisory on June 10, 2010 recommending that pharmacists provide only one refill for prescriptions after the death, retirement, or relocation of the prescribing physician. KHPA follows the current Kansas statute, which recognizes the validity of prescriptions for a full year.
- Loading and maintaining DEA registration numbers in the MMIS, to authenticate the prescribers of controlled substances and ensure they are authorized to prescribe these drugs.
- Strengthening edits designed to stop payment of duplicate claims.

The OIG wishes to thank the KHPA staff members who provided data and assistance throughout the course of the audit. These individuals include Pharmacy Program Manager LeAnn Bell, Shelly Liby, Karen Kluczykowski, Tammy Demmitt, Tracy Wagner, Cynthia Ludwig, Joshua Mast, and Jeanine Schieferecke.

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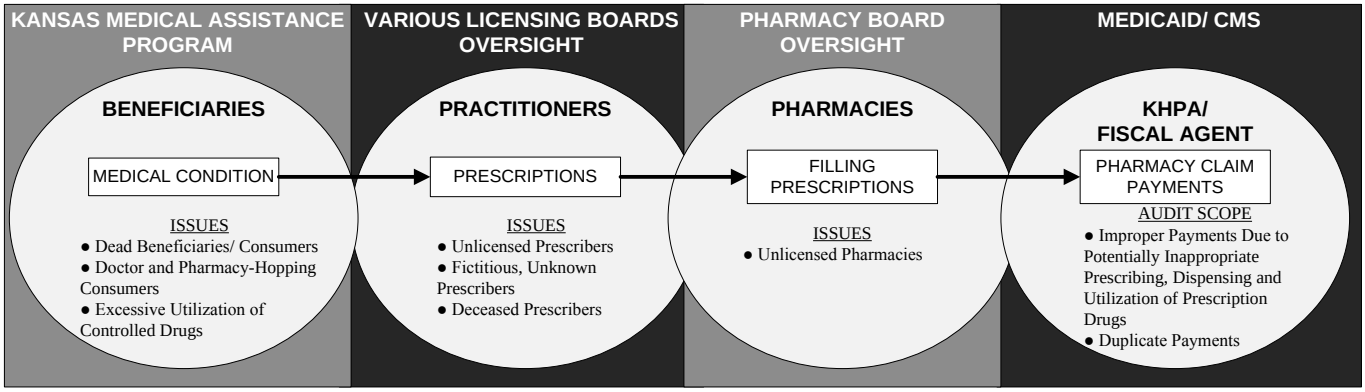
Audit Scope and Methodology

The State's Medicaid Fee-for-Service (FFS) Program provides prescription drug coverage primarily for low income, aged and disabled persons. According to Pharmacy program officials, Medicaid prescription drug expenditures have increased in recent years due in part to an increase in the cost per prescription and increased utilization of mental health drugs. In FY 2009, Kansas Medicaid paid $176.3 million or 10 percent of total Medicaid FFS spending for prescription drugs.

This audit addresses the question of whether KHPA has effective controls to prevent payment of several types of improper pharmacy claims. Improper payments examined in this audit include:

1. Payments for drugs ordered for deceased Medicaid beneficiaries,
2. Payments for drugs prescribed by practitioners no longer authorized to prescribe by their respective licensing boards, as well as, deceased, fictitious or unknown prescribers,
3. Payments for claims billed by pharmacies no longer licensed by the Board of Pharmacy,
4. Payments for excessive quantities or dosages of drugs without proper approval or appropriate justification.

The chart below shows a simplified prescription flowchart and includes various relevant oversight entities. It also identifies the specific issues or problems reviewed in this audit.



To complete this audit, we obtained Medicaid Management Information System (MMIS) paid pharmacy claims data, various state licensing boards' monthly licensing data, and death data from KDHE Vital Statistics for calendar years 2007 to 2009. We interviewed KHPA and fiscal agent Medicaid FFS pharmacy program managers to gain an understanding of the Pharmacy Program, including any control activities to prevent or detect improper or potentially fraudulent claims for prescription drugs. We also interviewed Board of Pharmacy officials to gain knowledge about the Board's role in overseeing pharmacists and pharmacies. Furthermore, we reviewed reports on national pharmacy or prescription drug trends by the Council of State

Governments, the National Center for Addiction and Substance Abuse at Columbia University and several other organizations. We also requested information on applicable federal pharmacy guidelines from Centers for Medicare and Medicaid Services (CMS) Regional Office staff, and we reviewed State and federal laws and regulations applicable to the Pharmacy Program.

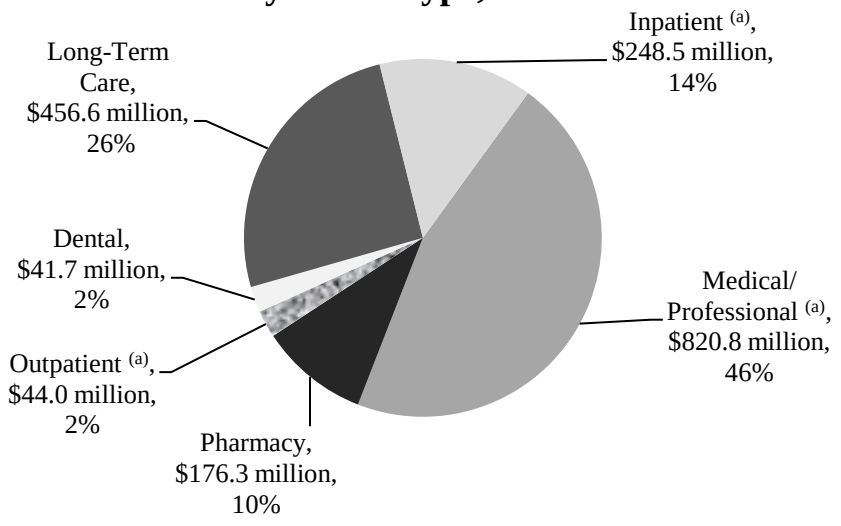
Our scope of work is limited to the types of improper payments listed above. We did not assess the validity of MMIS data but relied on the Statement on Auditing Standards 70 (SAS-70) annual review process and the CMS certification review process. We also did not assess the validity of data not maintained by KHPA, such as the KDHE Vital Statistics death data and the various State licensing boards' data. Because the various data we received did not have consistent formatting, our computer-assisted audit techniques may not have identified all potentially improper payments. Furthermore, our pharmacy claims data was limited to paid FFS pharmacy claims and did not include Medicare Part D co-payments paid by Medicaid. If additional analyses or targeted provider audits had been performed, other reportable matters might have come to our attention that may need corrective action. Such procedures would require more time than was intended for this audit.

Overview of KHPA's Pharmacy Program

The Kansas Legislature tasked the Kansas Health Policy Authority with administering the Medicaid Program under K.S.A. 75-7405. Medicaid pays for the care of low income, aged and disabled persons and is jointly funded by the state and federal governments. In fiscal year 2009, 60.08 percent of the Medicaid program was funded by Federal Financial Participation (FFP), 33.72 percent was funded by the State General Fund (SGF) and 6.20 percent was funded by the American Recovery and Reinvestment Act of 2009 (ARRA).

Prescription drug coverage is considered an optional service in Medicaid. However, all states have chosen to provide this benefit although policies, procedures and benefits vary from state to state. The State's Medicaid Pharmacy program is a Fee-for-Service (FFS) program and includes all prescribed medications provided through pharmacies.[1] As seen in chart OV-1, prescription drugs were 10 percent of the total spending in the Medicaid FFS program in FY 2009.

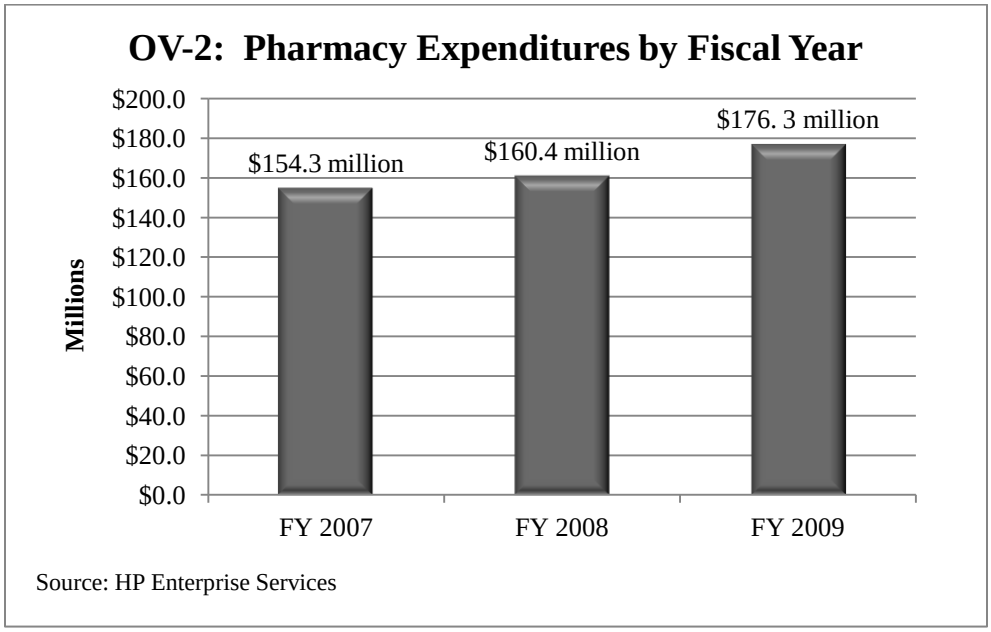
OV-1: Medicaid Fee-for-Service Expenditures by Claim Type, FY 2009



(a) Includes Medicare Crossovers
Source: HP Enterprise Services

[1] Prescription drugs administered in an institutional or inpatient setting are not included in the FFS pharmacy program but paid through facility reimbursements. In addition, prescription drugs dispensed to Medicaid beneficiaries participating in the HealthWave managed care program are reimbursed through that program. However, some drugs excluded from HealthWave coverage are paid through the FFS program.

From FY 2007 through 2009, Kansas Medicaid paid a total of $491.1 million for prescription drugs.[2] The graph OV-2 illustrates the trend in pharmacy expenditures for those three fiscal years which have risen 14 percent due in part to increases in the cost per prescription and increased utilization of mental health drugs.[3]



Pharmacy Program Oversight

Managers are challenged to implement controls that provide reasonable assurance against fraud without being too costly for government agencies or too burdensome for the providers and beneficiaries. In addition to controls that KHPA has installed, the process that includes the prescribing, filling, and paying for prescription drugs involves a number of entities that operate both cooperatively and independently. Their activities and processes, along with controls implemented by KHPA, form the control environment for prescription drug claims.

The Kansas Medicaid Pharmacy Senior Program Manager has oversight of the Medicaid Fee-for-Service Pharmacy program. The Senior Program Manager works closely with the fiscal agent, HP Enterprise Services, Pharmacy Unit. The fiscal agent Pharmacy Unit's tasks include:

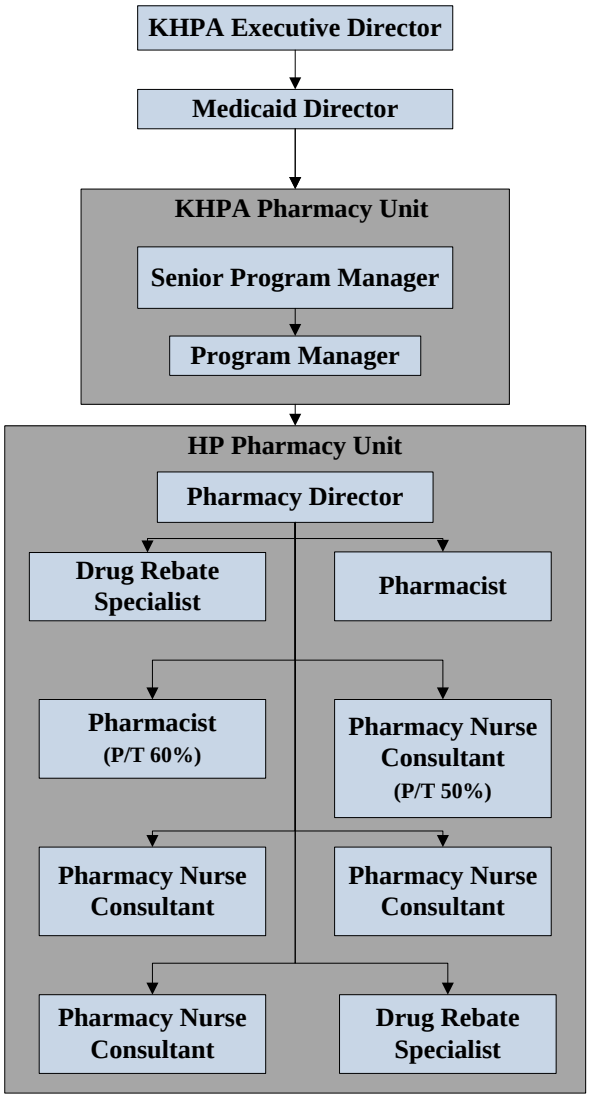
- Providing accurate, succinct information to other fiscal agent staff, State staff and providers.
- Identifying possible inappropriate drug therapy patterns, thereby enhancing the quality of care to beneficiaries.

[2] HP Enterprise Services provided amounts.
[3] KHPA Program Review of Pharmacy Services, Jan. 2009, p. 108

- Reducing KMAP's costs with cost savings initiatives.[4]

Chart OV-3 is an organizational chart illustrating the positions and relationships in the Kansas Medicaid Pharmacy Program.

OV-3: MEDICAID PHARMACY ORGANIZATIONAL STRUCTURE



Source: KHPA & HP Organizational Charts.

[4] Pharmacy Benefits Management Business Practice Manual, Rev. 8/30/10, Version 1.5, p. 1-1

Cost Saving Measures and Legislation Impacting the Pharmacy Program

Kansas and other states have developed cost saving measures and policies to help control Medicaid pharmacy expenditures. Some of these cost savings measures include: preferred drug lists, prior authorization,[5] required use of generic drugs, copayments, and limits on prescriptions. In addition to the actions taken by individual states, several federal laws have been enacted that have made an impact on prescription spending in Medicaid.

Omnibus Reconciliation Act of 1990

The Omnibus Reconciliation Act of 1990 required each Medicaid program to establish a Drug Utilization Review (DUR) program for outpatient drugs. In Kansas, the Drug Utilization Review Board includes four physicians, four pharmacists and one advanced registered nurse practitioner or physician's assistant. Their appointments are for a three year term. Some of the tasks of the DUR Board according to K.S.A. 39-7, 118 include:

- Monitoring of prescription information including overutilization and underutilization of prescription-only drugs;
- Reviewing the increasing costs of purchasing prescription drugs and making recommendations on cost containment;
- Reviewing profiles of Medicaid beneficiaries who have multiple prescriptions above a level specified by the Board; and
- Recommending any modifications or changes to the Medicaid prescription drug program.[6]

Medicare Part D

One piece of legislation affecting Medicaid was the Medicare Prescription Drug, Improvements and Modernization Act of 2003. This made a major change in both the Medicaid and Medicare programs as it established the Medicare Part D benefit. This change affected approximately 6.2 million beneficiaries who were dually eligible for Medicaid and Medicare.[7] Due to this Act, Medicare became the primary source of drug coverage for dually eligible beneficiaries which caused a drop in Medicaid's share of pharmacy expenditures from 70 percent to 24 percent for these beneficiaries.[8]

Deficit Reduction Act of 2005

Another major change to Medicaid spending took place when the Deficit Reduction Act of 2005 was enacted. An important provision of the DRA was to improve states' ability to collect drug

[5] Prior Authorization is a process where prescribers obtain approval before the dispensing of a particular drug.
[6] Kansas Legislature website; http://www.kslegislature.org/legsrv-statutes/getStatuteInfo.do
[7] State Perspectives on Emerging Medicaid Pharmacy Policies and Practices, NASMD, Nov. 2006, p. 6
[8] Kaiser Family Foundation Prescription Drug Trends Report, May 2010, p.2

rebates for physician-administered and authorized generic drugs. Drug manufacturers whose medications are dispensed to Medicaid patients are required to pay rebates to states for outpatient drugs dispensed or administered to Medicaid beneficiaries.

In Kansas, implementing the Preferred Drug List (PDL) helped in controlling costs. For drug classes where multiple drugs can be considered safe and effective, states may add specific drugs to their PDL. This allows the state to negotiate reduced prices (through supplemental rebates) with pharmaceutical manufacturers.[9] The use of generic drugs is also encouraged to control expenditures as almost 80 percent of FDA approved drugs have generic counterparts.[10]

According to pharmacy program staff, in Kansas, Medicaid is statutorily prohibited from restricting use of mental health drugs. K.S.A. 39-7,121b states:

> No requirements for prior authorization or other restrictions on medications used to treat mental illnesses such as schizophrenia, depression or bipolar disorder may be imposed on Medicaid recipients. Medications that will be available under the state Medicaid plan without restriction for persons with mental illnesses shall include atypical antipsychotic medications, conventional antipsychotic medications and other medications used for the treatment of mental illnesses.[11]

HealthWave Managed Care

Another major change in the Kansas Medicaid Pharmacy program occurred in January 2007 when approximately 50,000 beneficiaries from the FFS program were moved to the HealthWave managed care program.[12] KHPA pays managed care organizations (MCOs) a monthly per capita fee for each eligible beneficiary based on demographic such as region, population code, age, and gender.

[9] Advancing Efficient Management and Purchasing of Prescription Drugs By Jeffrey S. Crowley, Health Policy Institute, Georgetown University, and Edwin Park, Center on Budget and Policy Priorities, p. 2
[10] Kaiser Family Foundation Prescription Drug Trends Report, May 2010, p.4
[11] Kansas Legislature website; http://www.kslegislature.org/legsrv-statutes/getStatuteInfo.do
[12] KHPA Program Review of Pharmacy Services, Jan. 2009, p.108

I. Does KHPA's System of Controls Prevent Payment of Claims for Drugs Allegedly Dispensed for Deceased Beneficiaries?

Federal regulations[13] require that states have a statewide program of control of the utilization of all Medicaid services and a state plan that provides for methods and procedures to safeguard against unnecessary utilization of care and services. The state Medicaid agency is required to take reasonable actions to recover overpayments in accordance with state law and procedures. Overpayments may result from fraud and abuse or other situations or may be identified through federal reviews.

There have been reports in other states where individuals or pharmacies have submitted claims using fictitious beneficiaries, as well as, deceased or current beneficiaries' valid Medicaid numbers to acquire drugs or defraud the Medicaid program.[14] In this audit, the OIG looked at whether KHPA paid for prescriptions allegedly ordered for deceased beneficiaries. We have identified risks associated with deceased beneficiaries, as follows:

- First, there is the risk that someone, either one of the beneficiary's family members or a worker at a pharmacy, could use a deceased beneficiary's Medicaid number to illegally acquire prescription drugs.
- Second, there is the risk that a dishonest pharmacy could use the deceased beneficiary's Medicaid number to receive Medicaid payments for fictitious or fraudulent claims.

There may be valid reasons why claims were processed and paid after a beneficiary already was deceased. For example, the pharmacy not knowing of the beneficiary's death dispensed the prescription. However, if no one picked up the drug, the pharmacy has an obligation to reverse the claim. If someone picked up the drug knowing the intended recipient already died, that person may have committed fraud. To minimize risks related to fraud and abuse, KHPA should promptly and accurately update beneficiary dates of death.

In this audit, we matched the social security numbers of Medicaid beneficiaries with the social security numbers of deceased individuals reported to KDHE Vital Statistics. We initially found matches for 37 beneficiaries. Since we did not assess the validity of KHDE Vital Statistics death data and did not review KHPA's Medicaid eligibility determinations, we subsequently excluded 24 beneficiaries who share the same social security numbers with deceased individuals from Table I-1 on the next page.

[13] 42 CFR 456

[14] Pharmacist Headed to Prison, San Antonio Express-News (TX) – September 4, 2010; Raising the dead in Medicaid 'rip-offs,' New York Post – March 8, 2010; Pharmacist convicted of fraud to get, sell pills. – The Press of Atlantic City – May 20, 2009

OIG staff found 15 claims for 13 beneficiaries paid by Medicaid for prescription drugs dispensed after the beneficiaries' death. The dates of death for 11 of these beneficiaries had not been entered in the MMIS until one to three years after the fact. KHPA's pharmacy program manager researched these cases and informed us that all 13 beneficiary cases had been closed at some point. Any additional claims submitted after a deceased beneficiary's Medicaid case is closed will not be paid. The time lag from the date the beneficiary died to the date the beneficiary's case is closed in KAECSES by the eligibility worker may account for the overpayments we found a month after the beneficiaries' death. Because eligibility workers failed to enter the dates of death in KAECSES, the overpayments identified in Table I-1 were not flagged by SURS' annual death date audits. Eligibility workers process beneficiary enrollments and are responsible for entering dates of death in KAECSES, which feeds beneficiary data to the MMIS.

I-1: Sample Payments for Prescriptions Dispensed for Dead Beneficiaries

Beneficiary	City	KDHE Death Date	Drug Dispensed Date		Potential Overpayment
			From	To	
1	Scott City	11/28/2007	12/3/2007	12/3/2007	$1,516
2	Wichita	4/4/2009	4/6/2009	4/6/2009	$187
3	El Dorado	2/25/2007	2/28/2007	2/28/2007	$63
4	Olathe	7/21/2009	7/23/2009	7/23/2009	$38
5	Lenexa	5/24/2009	5/25/2009	5/25/2009	$38
6	El Dorado	9/18/2008	10/13/2008	10/13/2008	$33
7	Ellinwood	1/24/2007	1/27/2007	1/27/2007	$22
8	Olathe	7/21/2008	8/14/2008	8/14/2008	$18
9	Kansas City	8/21/2007	8/29/2007	8/29/2007	$15
10[(a)]	Wichita	12/23/2008	12/24/2008	12/24/2008	$12
11	Junction City	7/11/2007	7/26/2007	7/26/2007	$8
12	Wichita	10/3/2008	10/15/2008	10/15/2008	$4
13[(b)]	Minneapolis	2/17/2009	2/18/2009	2/18/2009	$4
				Total	**$1,958**

(a) MMIS date of death is 12/24/2008
(b) MMIS date of death is the same.
Source: OIG analysis of KDHE Vital Statistics death data and MMIS paid pharmacy claims.

Potential overpayments related to 10 of the 13 beneficiaries were for less than $50. Prescriptions for nine of the 13 beneficiaries were dispensed within 10 days of the date of death. According to the KHPA pharmacy program manager, Beneficiary #1 who accounted for about 75 percent of the total amount overpaid, was a newborn. In this case, the pharmacy program manager called the pharmacy and was informed the prescription was ordered on a Wednesday, the day the newborn died. The pharmacy was not informed the newborn had already died and the drug was mailed out the following Monday. In this case, she said the overpayment should not be recouped

because the newborn was alive when the request for refill was made, and once the drug had left the pharmacy, by law it could not be returned.

Surveillance and Utilization Review Death Date Audits

KHPA's fiscal agent Surveillance and Utilization Review Subsystem (SURS) staff conducts post-payment reviews[15] of claims billed for deceased beneficiaries after their date of death. SURS staff uses dates of death already in MMIS in these death date audits.[16] The death dates are loaded in the MMIS through KAECSES, the state's eligibility system.

According to KHPA staff, SRS receives a file from KDHE every week detailing new deaths. SRS matches that file to people who are Medicaid eligible and creates a list, which is then distributed to local eligibility workers. Eligibility workers verify whether a beneficiary is really deceased by contacting the beneficiary's facility, family member or whomever is appropriate. If the eligibility worker confirms the beneficiary is really deceased, the eligibility worker closes the beneficiary's Medicaid case, which terminates the beneficiary's eligibility, and enters the date of death in KAECSES. According to SURS staff, they verify the date of death is correct through the Social Security Administration database only if there are inconsistencies or concerns noted.

According to SURS staff, a "typical" case involves a pharmacy that supplies medication to a long-term care facility. The beneficiary dies but the long term care facility fails to timely notify the pharmacy. The pharmacy subsequently dispenses medication to the long-term care facility and bills Medicaid after the beneficiary's date of death. SURS staff has not found any pharmacy cases where the pharmacy billed after a beneficiary's death and showed a suspicious billing pattern or that appeared fraudulent.

The SURS staff identified $26,386 in pharmacy claim overpayments related to deceased beneficiaries in CY 2008, and $27,692 in CY 2009. So far, they have recouped 97 percent and 99 percent of overpayments identified in CY 2008 and CY 2009, respectively. According to SURS staff, any pharmacy claim paid immediately after the beneficiary's date of death is considered an overpayment and identified for recoupment from the pharmacy.

Since data we covered in this audit is only up to December 2009, eligibility staff had sufficient time to update death dates of beneficiaries who died in CY 2009 and SURS staff had sufficient time to complete their annual date of death audit. This accounts for the small number of pharmacy claims for deceased beneficiaries we found, compared to SURS identified overpayments for the same time period.

A KHPA OIG survey of other states found that Arkansas and Wyoming acquire computerized death information on a weekly or monthly schedule from their state's Office of Vital Statistics.

[15] See Appendix C for information on SURS provider reviews and related overpayments.
[16] If a beneficiary has no date of death in the MMIS, SURS staff excludes the beneficiary from the death date audit.

<u>Conclusion</u>: KHPA incurs minimal loss of funds due to paying for prescription drugs for deceased beneficiaries. KHPA's post-payment death audits appear to be reasonably effective in identifying overpayments related to drugs allegedly dispensed for deceased beneficiaries. However, it is essential that beneficiary death dates are promptly and accurately updated to minimize overpayments and control the risk of unauthorized individuals obtaining fraudulent payments or drugs using the identification number of a deceased beneficiary.

A reasonable amount of time lag in updating beneficiary death dates in KAECSES, and therefore in MMIS, is expected. However, KHPA could gain some efficiency by loading death data directly from an official government source such as the Social Security Administration. While this will not prevent claims from being paid after beneficiaries die, it increases the probability that death dates are updated in MMIS, ensures that pharmacy claims paid after beneficiaries die are flagged in the annual death date audits, and could reduce amounts to be recovered through pay and chase.

Recommendation

1. KHPA should update KAECSES or MMIS death dates promptly and accurately using KDHE Vital Statistics death data or the Social Security Administration death database.

II. Does KHPA's System of Controls Provide Reasonable Assurance That Prescribers in Pharmacy Claims Are Authorized and Licensed?

Federal Regulation 440-120(a) defines prescribed drugs as those prescribed by a physician or other licensed practitioner of the healing arts and dispensed by licensed pharmacies and licensed authorized practitioners in accordance with the State Medicaid Practice Act. Establishing the legitimacy of the prescriber in paid claims is essential for the following reasons:

- Ensuring legal compliance
- Helping thwart fraud
- Helping authenticate the claim
- Helping protect public safety by ensuring that healthcare professionals prescribing drugs for Medicaid beneficiaries have maintained their license to practice.

Thus, it is essential for the MMIS to include edit and audit controls that help ensure the legitimacy of the prescriber. This sentiment was echoed by a Health and Human Services OIG official in his testimony to a subcommittee of the U.S. Senate Committee on Homeland Security and Governmental Affairs, discussing payment accuracy safeguards in the Medicare Part D prescription drug program.

"Because prescriber identifiers are a key indicator on claims that link prescribing physicians, dispensing pharmacies and beneficiaries, they play a critical role in program integrity efforts. Without a valid prescriber identifier, it is difficult to determine if a physician even prescribed a drug, much less verify that the physician was appropriately licensed or had not been excluded from the program. Furthermore, invalid prescriber identifiers inhibit OIG investigations by making it more difficult to identify questionable prescribing patterns and the parties responsible for potential fraud."[17]

We talked to KHPA's pharmacy program managers to better understand and evaluate existing prescriber controls. We reviewed KHPA's pharmacy provider manual to identify relevant policies and instructions to providers. We also reviewed the MMIS list of edits and audits to identify prescriber edits.

In 2008, KHPA made a change that improved its prescriber controls. As stated in KHPA's pharmacy provider manual, as of April 1, 2008, pharmacy providers are required to submit the prescribing provider's unique national provider identifier (NPI) or KMAP provider number when submitting a paper claim. All electronic claims for covered drugs, including refills, are required

[17] Testimony of Robert A. Vito, Acting Assistant Inspector General – CMS OIG, before the U.S. Senate Committee on Homeland Security and Governmental Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services and International Security. July 15, 2010.

to have the prescribing providers' NPI, and all claims must be substantiated by a prescription from a licensed practitioner as required by federal and state laws. Prescriptions are required to be on file at the dispensing pharmacy.[18]

With the NPI implementation, KHPA created three prescriber edits designed to deny[19] claims with invalid prescribers, as follows:

- *Edit 646 - prescribing provider ID qualifier missing or invalid*. Set to pay and list on May 23, 2007 and to deny on April 1, 2008, this edit drives the prescribing provider edits for pharmacy claims. If the NPI qualifier[20] is submitted, the NPI is captured on the claim and assessed to determine whether it passes the Luhn formula. If the NPI submitted does not pass the Luhn formula or is missing, Edit 649 would deny the claim. For paper claims, the KMAP ID qualifier may be submitted. If the qualifier is missing or other than the NPI or KMAP ID qualifier is present, the claim would deny.

- *Edit 648 - prescribing provider type not allowed.* This edit would deny a claim when the prescriber as identified by his NPI or KMAP ID is not allowed to prescribe drugs.[21] Prescribing provider types allowed to prescribe are advanced practice nurses, mid level practitioners, podiatrists, optometrists, dentists and physicians. This edit only works when the prescriber is a Kansas Medicaid enrolled provider.

- *Edit 649 - NPI prescribing provider ID missing or invalid.* This edit would deny an electronic claim when the prescriber NPI is invalid or missing. For claim adjustments[22] prior to May 23, 2008 or claim adjustments with a missing NPI but with a valid KMAP ID, this edit is bypassed and the claim is processed. If the NPI was not valid on the original claim, the denied claim cannot be adjusted. When the prescribing provider is not required to have an NPI,[23] pharmacies should submit a paper claim using the prescribing provider's KMAP ID. However, prescribing providers are not required to be enrolled as KMAP providers.

KHPA's 2003 prescriber edit, Edit 205, was originally designed to deny a claim if the KMAP prescribing provider number was missing, not numeric, less than nine digits or more than nine digits. However, according to pharmacy program managers, beneficiary access to care concerns resulted in a subsequent policy change to use the prescriber's license number and not the KMAP provider ID. According to MMIS edit records, the numeric check was discontinued since license numbers can have non-numeric characters and the length check was discontinued as well since different states can have different lengths.

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[18] KMAP Pharmacy Provider Manual, July 6, 2010. See https://www.kmap-state-ks.us/public/providermanuals.asp
[19] For region 91, the edits are dispositioned to suspend.
[20] NPI=01, KMAP ID=05, DEA ID=12. Effective April 1, 2008, the DEA qualifier was no longer accepted. KMAP IDs are accepted only on paper claims.
[21] This edit will deny a claim based on the prescriber's submitted or crosswalked KMAP ID.
[22] Regions beginning with 5
[23] Prescribers who do not submit electronic claims

Edit 205 was superseded by NPI-related edits 646, 648 and 649. We looked at the MMIS reports CLM-0055-D and CLM-6516-D and verified that Edits 646, 648 and 649 are currently being used and reject a number of claims daily that do not meet edit criteria.[24]

Our findings related to whether existing MMIS controls are adequate in ensuring only pharmacy claims with authorized and licensed prescribers are paid, are as follows:

As a result of its implementation of NPI related edits in May 2008, KHPA's revised controls appear reasonably effective in preventing payment of pharmacy claims with missing prescribers. To test whether KHPA is paying pharmacy claims with missing prescribers, we identified paid pharmacy claims from CY 2007 to CY 2009 with a prescriber field that is blank or has an entry of a series of zeros or a series of nines, without a corresponding prescriber KMAP ID.[25] Our results are shown in Table II-1 below.

II-1: Sample Paid Claims with Missing Prescribers CY 2007 – 2009 [(a)]

Quarter Paid	Potential Overpayment	Number of Claims
JAN-MAR 2007	$215,849	3,173
APR-JUN 2007	$318,600	3,914
JUL-SEP 2007	$625,026	7,183
OCT-DEC 2007	$792,596	8,473
JAN-MAR 2008	$864,599	9,511
APR-JUN 2008	$97,163	1,094
TOTAL	$2,913,832	33,348

[(a)] Our analysis did not find paid claims with missing prescribers after the quarter ending June 2008 to December 2009.
Source: OIG analysis of MMIS paid pharmacy claims data.

From January 2007 to the quarter ending June 2008, 33,348 pharmacy claims totaling more than $2.9 million with missing prescribers were submitted and paid. We did not find any paid claims with missing prescribers after the quarter ending June 2008. The decline in the number of claims with missing prescribers could be attributed to KHPA's implementation of NPI related edits in April 2008. According to KHPA's fiscal agent pharmacy program manager, prior to April 1, 2008, as long as the prescriber field had an entry, e.g. a dot, the claim would pay. There was also a short-lived period when they required DEA numbers in the prescriber field.

For prescribers not enrolled as Kansas Medicaid providers, KHPA has inadequate controls to prevent payment of pharmacy claims with invalid prescribing provider types. KHPA's edit to

[24] We looked at CLM-0055-D reports 10/29/09 to 11/22/09 and CLM-6516-D reports 7/1/09 to 7/31/09.
[25] There are many other entries that constitute invalid numbers not included in this analysis. We did not expand our analysis to include other potentially invalid numbers or letters due to time constraints.

deny claims with invalid prescribing provider types[26] is only effective when the prescriber is a Kansas Medicaid enrolled provider. For non-enrolled prescribers, the information captured in the MMIS is only an NPI, which by itself, is insufficient to determine the prescriber's provider type. This issue also applies to prescribers who were Kansas Medicaid providers but who terminated their practice for voluntary or involuntary reasons. According to KHPA's pharmacy program manager, once the provider's KMAP number is deactivated in MMIS, it would no longer be available to match or cross walk to the prescriber NPI submitted on the pharmacy claim.

For prescribers not enrolled as Kansas Medicaid providers, KHPA's Luhn formula is not sufficient to ensure the NPI submitted belongs to an actual healthcare provider or to the individual who actually prescribed the drugs. For prescribers not enrolled as Kansas Medicaid providers, MMIS' only control is the Luhn formula, also called modulus 10.[27] As long as the prescriber NPI submitted passes the Luhn formula, the MMIS will pay the claim, assuming all other information associated with the claim is correct. Since fewer controls exist for non-enrolled providers, claims they submit are at higher risk for potential fraud.[28]

To determine the number of paid pharmacy claims with non-Kansas Medicaid prescribers, we looked at paid pharmacy claims in calendar year 2009 without a submitted or crosswalked KMAP ID in the prescriber field, and found 204,336 claims totaling $14.0 million. This represents about eight percent of $176.9 million in claims paid in CY 2009. Since the prescribers' identities and licenses were not verified, KHPA could not be certain that these claims were based on prescriptions written by licensed prescribers. We looked up four prescriber NPIs and verified these numbers against the Centers for Medicare and Medicaid Services (CMS) NPI Registry.[29] Here is what we found:

- *Fictitious Prescriber NPIs.* Prescriber numbers 9999999995 and 9999999920 were not registered in CMS' NPI Registry. These two fictitious prescriber numbers prescribed 24 prescriptions totaling almost $2,000 in CY 2009.

- *Kansas pays expensive prescriptions ordered by non-Kansas Medicaid enrolled providers.* One non-Kansas Medicaid enrolled pediatrician in Oklahoma City prescribed almost $700,000 of antihemophilic drugs in 2009 to a Kansas beneficiary under the HealthWave managed care program.[30] According to pharmacy program managers,

[26] Edit 648
[27] http://searchsecurity.techtarget.com/sDefinition/0,,sid14_gci214514,00.html.
[28] KHPA currently does not collect data on non-KMAP enrolled providers, other than the NPI.
[29] The NPI Registry contains providers' National Plan and Provider Enumeration System (NPPES) information, developed by CMS to assign standard unique identifiers for health care providers and health plans as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The purpose of the NPI provisions is to improve the efficiency and effectiveness of the electronic transmission of health information.
[30] Medicaid Fee-for-Service (FFS) pharmacy program includes costly medications used to treat hemophilia and acquired immunodeficiency syndrome (AIDS) excluded from managed care organization capitation rates.

Kansas does not have a CDC Hemophilia Treatment Center but Oklahoma City has one, so this case is not necessarily suspect.

According to Oklahoma's pharmacy director, Oklahoma requires a provider's NPI match a list of approved prescribers in their system. While KHPA does not have similar or tighter control and relies only on the Luhn formula, it is possible the provider belongs to the provider network of the managed care organization handling the beneficiary's care.

- *Prescriptions may continue to be dispensed after Kansas Medicaid enrolled providers relocate their practice out of state.* One former Kansas physician moved to Hawaii and was reported inactive by the Board of Healing Arts effective July 2009. His KMAP ID was deactivated. However, over 1,100 prescriptions or refills totaling almost $110,000 were reported prescribed by the physician and dispensed after he was reported inactive and his KMAP ID deactivated. Currently, state laws allow prescriptions to be refilled up to one year after the prescription was originally issued.[31]

  A June 2010 Board of Pharmacy advisory suggests, in cases where a doctor has died, retired or relocated, one refill is acceptable to allow the patient time to find a new care provider. After that, a prescription loses its validity.[32] This recent Board advisory is based on a Food and Drug Administration (FDA) opinion that a prescription by a practitioner given to a patient signifies generally that a physician/patient relationship exists and that, once a physician/patient relationship is broken, the prescription loses its validity since the physician is no longer available to treat the patient and oversee his or her use of the prescribed drug(s).

KHPA currently does not have adequate controls to prevent payment of claims for drugs prescribed by practitioners not in good standing with their licensing boards. K.S.A. 65-2803 says it is unlawful for any person not licensed under the Kansas Healing Arts Act or whose license has been revoked or suspended to engage in the practice of the healing arts in Kansas.[33] In addition, K.S.A. 65-2809 says physicians with an inactive license are not allowed to prescribe or practice in Kansas.[34]

We analyzed paid pharmacy claims data and various Kansas healthcare boards' licensing data to determine whether any claims were paid for drugs prescribed by practitioners with an unauthorized license status in Kansas in CY 2007 to 2009. Our findings are shown in Table II-2.

[31] KSA 65-1637, KAR 68-2-20(b)(2). Current policy allows controlled substances to be refilled only up to 6 months.
[32] Kansas State Board of Pharmacy News, June 2010, p.4, http://www.kansas.gov/pharmacy/Newsletters/June2010.pdf; 2009 regulatory update to KAR 68-2-20(a)(2).
[33] KSA 65-2891 authorizes any health care provider who in good faith renders emergency care or assistance at the scene of an emergency or accident.
[34] Other licensing boards have similar statutes addressing suspended or revoked licenses.

II-2: Paid Claims For Prescriptions Ordered by Inactive or Suspended Kansas Physicians CY 2007-2009		
Calendar Year	Paid Claims	Number of Unauthorized Prescribers [(a)]
2007	$92,832	78
2008	$79,339	53
2009	$37,896	39
TOTAL	$210,068	126 [(b)]

[(a)] Unauthorized means a licensee with a board license status of suspended, revoked, inactive, cancelled, retired, disabled, surrendered or deceased on monthly reports from various state healthcare licensure boards.
[(b)] Number of unique prescribers (unduplicated). We have excluded two prescribers with erroneous license numbers in the MMIS.
Source: OIG analysis of monthly licensure data from various state healthcare boards and MMIS paid pharmacy claims data.

For calendar years 2007 to 2009, KHPA paid about $210,000[35] representing 3,575 claims for drugs ordered by physicians after their license was rendered inactive or suspended by the Kansas Board of Healing Arts. KHPA currently has no edits that check to see whether prescribers are in good standing with their licensing boards and have current licenses. We took a closer look at a few prescribers included in II-2. Here is what we found:

- In CY 2007 through 2009, three physicians with inactive licenses prescribed drugs costing as much as $27,000, $26,000 and $9,000, respectively. However, these three physicians are currently licensed to practice in Missouri. One has offices located in Joplin, Missouri, while the other two have offices in Kansas City, Missouri.

- In January 2007, a physician practicing in Wichita, Kansas, was ordered by the Board of Healing Arts not to engage in any patient care activities. His license to practice the healing arts was temporarily suspended pending a formal hearing. In CY 2007, KHPA paid claims totaling over $6,000 for prescriptions allegedly ordered by the physician at the time of his suspension. His suspension was lifted in February 2008.

- A physician practicing in Overland Park, Kansas, had an active license until September 2007. He had an inactive Kansas license from October 2007 to July 2008 when he moved to Plano, Texas. In August 2008, he again relocated his practice to Kansas City, Missouri, and acquired an active Kansas license. KHPA paid claims totaling about $16,000 for prescriptions he allegedly ordered for Kansas Medicaid beneficiaries at the time he

[35] The actual amount may be higher. Our computer-assisted audit analysis was limited by the licensing boards' different license number formats, which differ from MMIS' license number format. In addition, we excluded records with missing status months and other fields from our analysis.

apparently was in Texas.

- A physician located in Kansas City, Kansas had an exempt status until April 2007, after which, he became inactive. KHPA paid claims totaling over $10,000 for prescriptions he allegedly ordered at the time he was inactive.

KHPA has access to monthly licensing data through its data management unit. According to staff, they collect the data monthly from various state healthcare licensing boards in accordance with K.S.A. 65-6801 through 65-6805 and 65-5001. The data management unit provides data reports for a fee when requested by private and public entities, but provides it free of charge to other state agencies, including the University of Kansas. Staff also provides quarterly reports to SRS for Child Support Enforcement (CSE) purposes, monthly reports to KDHE, as well as within KHPA on an ad hoc basis.

However, KHPA's program managers have not utilized this database to prevent claims for drugs ordered by unlicensed physicians from being paid. According to program managers, they have no access to the licensing data because there currently is no interagency agreement allowing Medicaid programs access to the data. Currently, KHPA's provider enrollment manager finds out if a prescriber/provider has lost his license through self disclosure, news media, manually checking the licensing boards' website, US Health and Human Services OIG notification letters and reports from other providers.

KHPA's pharmacy program manager pointed out that it may not be possible to recoup money from the pharmacy that filled a prescription written by a prescriber with an inactive or suspended license. To recover payments made, KHPA would need a reasonable expectation that the pharmacy knew or should have known about the suspended or inactive status of the physician. She also pointed out it is unreasonable to expect a patient to have learned about a suspension, found a new doctor, made an appointment, been evaluated and had all his drugs re-prescribed within a few days of the suspension.

KHPA currently does not have controls to prevent payment of claims for drugs allegedly prescribed by deceased physicians. This is a vulnerability that a person committing fraud or abuse could exploit by using a deceased physician's name and identifier. In addition, a pharmacy may inadvertently honor an old invalid prescription. OIG staff looked at a few prescribers to determine whether any paid pharmacy claim was prescribed by a practitioner reported deceased to KDHE Vital Statistics. We found three physicians, reported deceased to Vital Statistics, who appear to have prescribed drugs more than a year after their date of death. We received telephone confirmation of their death from their former workplaces. As shown in Table II-3, Kansas Medicaid paid over $10,000 in claims for drugs these three deceased physicians allegedly

prescribed. This amount excludes claims of almost $6,000 paid for prescriptions within a year after date of death.

II-3: Sample Overpayments for Prescriptions Dispensed Over 1 Year After the Prescriber's Death					
Provider	City	KDHE Death Date	Drug Dispensed Date		Overpayment
			From	To	
1	Lindsborg	5/10/05	12/27/06	11/8/07	$130
2	Overland Park	10/11/05	1/8/07	9/14/07	$361
3[(a)]	Coffeyville	2/8/06	2/17/07	10/5/07	$9,659
				Total	$10,150

[(a)] Total paid claims for prescriptions dispensed after this physician's date of death was $15,611.40.
Source: OIG analysis of KDHE Vital Statistics death data and MMIS paid pharmacy claims.

Section 6401(b) of the Patient Protection and Affordable Care Act, signed into law in March 2010, provides for screening and enrollment requirements for ordering or referring providers. States will be required to enroll all ordering or referring physicians or other professionals under the state plan or under a waiver of the plan as a participating provider. In addition, the NPI of any ordering or referring physician or other professional must be specified on any claim for payment that is based on an order or referral of the physician or other professional. The Act also allows CMS to conduct background checks, site visits, and other enhanced oversight to weed out fraudulent providers before they start billing the program, creates a national pre-enrollment screening program for all providers, and requires disclosure of prior association with delinquent providers or suppliers.

<u>Conclusion</u>: The vast majority of prescriptions for Kansas Medicaid beneficiaries are ordered by KMAP-enrolled prescribers. For these prescribers, KHPA has controls in place to validate their identity and determine whether their provider types are allowed to prescribe.

However, KHPA's current practice allows for paying some claims where the prescriber's identity and authority to prescribe cannot be verified, such as the case with out-of-state or non-KMAP-enrolled prescribers. In addition, while KHPA requires a copy of a renewed license upon license expiration of billing providers, it does not have similar procedures to validate that prescribers, whether KMAP-enrolled or non-KMAP-enrolled, have valid and current licenses and are in good standing with their licensing board when they order a prescription. KHPA should either revise its policy to deny payment for prescriptions ordered by prescribers whose identity, license and authority to prescribe cannot be verified or adopt alternative approaches to verify prescribers.

Recommendations

2. KHPA should utilize CMS' NPPES or NPI Registry for non-Kansas Medicaid enrolled providers and make sure NPI and name match to help authenticate the identity of the prescribers.

3. KHPA should use healthcare licensing boards' licensing data to ensure only claims for prescriptions ordered by prescribers in good standing with their licensing boards are paid. To implement this practice, KHPA management should consider the following options:
    a. Deny claims when the license status of the prescriber ordering the prescription cannot be verified.
    b. Obtain healthcare licensing data from surrounding states where Kansas Medicaid beneficiaries obtain prescriptions.
    c. Require all prescribers to enroll in Kansas Medicaid and deny claims for those prescribers whose license status is not in good standing with their licensing board.

4. KHPA should review its policy for allowing prescriptions to be refilled up to one year after the prescription was originally issued. The policy is in compliance with current law, but it conflicts with the recent June 2010 Board of Pharmacy advisory on the one-time validity of prescriptions which have lost their legitimate medical purpose due to the death, retirement or relocation of the prescribing physician.

5. KHPA should utilize KDHE's death data or the Social Security Administration's death database to promptly and accurately deny claims for prescriptions allegedly ordered by deceased prescribers. KHPA SURS staff should review exceptions and refer to MFCU, if records indicate potential fraud.

III. Does KHPA's System of Controls Provide Reasonable Assurance That Only Currently Licensed Pharmacies May Dispense Prescription Drugs and Receive Medicaid Payments?

The Board of Pharmacy exercises a number of important functions that contribute to controlling fraud and abuse. It licenses all pharmacies and pharmacists in the state. It requires all pharmacies to renew their licenses on an annual basis and revokes licenses for those who fail to renew on time. It receives complaints and investigates them. It conducts periodic inspections of pharmacies to ensure compliance with a variety of legal requirements. It also provides education to pharmacies and pharmacists regarding effective practices and legal requirements.

The Board of Pharmacy has issued guidelines for filling prescriptions. According to K.A.R. 68-2-20, all prescriptions must be filled under the supervision of a licensed pharmacist (see related statute in box below). This statute mandates the steps to be followed by the pharmacist in filling the prescription. In addition, KHPA provides instructions, benefits and limitations information in its provider manual for pharmacies to review and follow.

Pharmacist-in-Charge Requirement

K.S.A. 65-1637 requires every pharmacy to have a pharmacist-in-charge (PIC). This requirement is enforced by the Board of Pharmacy through licensing, inspections, and complaint investigations.

K.A.R. 68-2-5 requires PICs notify the Board of Pharmacy within five days of severing employment with a pharmacy. The pharmacy is then required by law to have a replacement PIC at the establishment within 30 days. The Board of Pharmacy monitors pharmacies for compliance with this requirement.

While the Kansas Medical Assistance Program (KMAP) requires pharmacies to submit a copy of the current license of the pharmacist-in-charge to be enrolled as providers, claims are not required to have, and do not have, PIC identification. KHPA's pharmacy claim adjudication does not enforce the PIC requirement.

Kansas law (K.S.A. 65–1643) requires pharmacies to obtain registration with the Board of Pharmacy. According to the Board of Pharmacy, there were 872 pharmacies licensed to operate in Kansas as of July 8, 2010. In calendar years 2007 through 2009, 794 pharmacies participated in the Kansas Medicaid Pharmacy program.

The Board of Pharmacy's practice of requiring annual licensing, coupled with its enforcement and inspection powers, prevent pharmacies from operating outside the law. The Board requires

all pharmacies to renew their licenses on or before June 30 each year. A grace period of one month is given to those that still want to renew after the deadline. Pharmacies can operate normally during this period. At the beginning of August, the Board of Pharmacy terminates the license of any pharmacy that has not renewed and assesses a penalty for those requesting reinstatement.

KHPA requires that its fiscal agent maintain a current copy of a license or certification on file for KMAP-enrolled providers. Thirty days prior to a provider's license expiration date, the fiscal agent sends a notice to the provider requesting proof of renewal. For those who fail to respond, second and third notices are sent. Providers must submit their renewed licenses within 30 days of the expiration date of their old ones; otherwise their KMAP IDs will be deactivated. Any claims submitted after deactivation of a billing provider's KMAP ID will be denied.

KMAP policy states that the effective date of KMAP ID deactivation is the day following the license expiration date. It also states that the program will recover any payments made for claims submitted during the one-month period during which the Board of Pharmacy accepts late renewals without assessing a penalty. Pharmacy providers are reminded of this policy through the standard license renewal reminder letter, as well as, the KMAP provider inactivation notification.

In general, pharmacies appear to have complied with licensing requirements. According to the Kansas State Board of Pharmacy, 97 pharmacies[36] in calendar years 2008 and 2009 let their licenses expire and did not renew. One pharmacy had its license revoked by the Board of Pharmacy during the audit period and ceased to participate in Medicaid after the revocation. According to one of the pharmacy program managers, two of the 97 pharmacies on the Board of Pharmacy's list had been terminated from the program in 2007. One did not re-enroll and the other closed its operations.

Two pharmacies were paid for prescriptions filled after they were terminated from Medicaid.
To assess the effectiveness of controls designed to deny claims submitted by terminated providers, the OIG analyzed claims submitted by the two pharmacy providers. One of these pharmacies requested to be terminated from Medicaid after being acquired by another organization. KHPA received the request on 7/7/2008. The request specifically asked for retroactive termination, with an effective date of 11/30/2007, which KHPA granted. Effective 11/30/2007, the organization that acquired this pharmacy became the pharmacy provider at the same location. However, records show that claims worth $242,232 for prescriptions filled after the new owners moved in were submitted and paid under the identity particulars of the old, terminated pharmacy.

[36] 53 in CY 2008 and 44 in CY 2009

The other pharmacy was terminated for failure to supply or maintain a license. The effective termination date was 06/23/2007. This pharmacy requested KHPA to make the termination effective 08/24/2007, but was denied. The total amount paid to this provider for prescriptions filled after the termination date of 06/23/2007 was $11,012.

Conclusion: KHPA's provider enrollment and licensing controls, together with Board of Pharmacy requirements, help minimize the likelihood that pharmacies can dispense drugs and obtain Medicaid payments after their licenses expire. However, the OIG noted one instance during the audit period where claims were paid for drugs dispensed after a pharmacy's license expired and one instance where claims were paid for drugs dispensed after a pharmacy's KMAP termination date.

Recommendations

6. KHPA should work with its fiscal agent to improve controls to ensure that no payments are made to pharmacies for drugs dispensed after expiration of the pharmacy's license. KHPA should also consider initiating recoupment action on the $11,012 paid for prescriptions filled during the period following the pharmacy's termination from Medicaid for failure to maintain a license.

7. KHPA should formulate a clear policy regarding the termination effective date in situations where providers request retroactive termination and there are claims paid for prescriptions filled beyond the date being requested. In addition, KHPA should review the pharmacy identified by OIG as having been terminated retroactively and determine whether to initiate recoupment of the $242,232 paid for claims filled beyond the termination effective date.

IV. Does KHPA's System of Controls Provide Reasonable Assurance against Duplicate Prescription Drug Claims?

Federal regulations[37] require that for all claims, the agency responsible for paying Medicaid claims must conduct prepayment claims reviews consisting of verification that each claim processed and paid does not duplicate or conflict with one reviewed previously or currently being reviewed.

The MMIS has two edits specific to pharmacy, designed to prevent payment of duplicate claims. One of the edits, Edit 5014, identifies claims as suspect duplicate if they match in all of the following data elements: *Beneficiary ID, Dispense Date, Billing Provider ID,* and *NDC*. The second edit, Edit 5015, identifies claims deemed to be exact duplicates. These are claims that have the same *Beneficiary ID, Dispense Date, Billing Provider ID, Billing Service Location Code* and *Prescription Number*.

Payments were made for duplicate claims. To determine whether Edit 5014 and Edit 5015 effectively identify and deny payments for duplicate prescription claims, the OIG analyzed claims paid between January 1, 2007 and December 31, 2009. We identified 34 suspect duplicate claims, with payments amounting to about $1,898. We also identified a further eight claims that appeared to be suspect duplicates for which a total payment of $14,728 was made. According to pharmacy program managers, the duplication of these eight claims was a necessity intended to provide a particular consumer with the appropriate dosage of a Schedule II medication to meet a medical need. The claims were split to force payment through point-of-sale adjudication. These claims therefore paid correctly. Our analysis for exact duplicates identified 32 claims amounting to $1,672. Of these claims, one duplicate pair was processed under Special Projects. In all, we found 66 duplicates or suspect duplicates for which a total payment of $3,570 was made.

In general, KHPA does not require pharmacies to submit copies of prescriptions dispensed to support claims, but requires them to keep original copies for possible review. Because KHPA does not review prescriptions with the exception of those flagged for review by SURS staff, it is doubtful the perceived threat of comparing electronic claims to written prescriptions provides an effective deterrent against fraud. On the other hand, KHPA's fiscal agent processed and paid over 2.7 million pharmacy claims in calendar year 2009. Thus, it would not be cost-effective or practical to require pharmacies to submit written prescriptions to validate all claims.

We talked to program managers in three states[38] who said they require pharmacies to periodically submit copies of prescriptions for a sample of claims or make onsite inspections of prescriptions. In Kansas, Board of Pharmacy Inspectors review paper prescriptions to see if they

[37] 42 CFR 447.50(f) (1) (iii)
[38] Alaska, Arkansas, Oklahoma

are being retained as required, but they do not compare them with claims to ensure claims are supported by written prescriptions.

<u>Conclusion</u>: The OIG analysis indicated that KHPA paid very few duplicate claims during the audit period. However, because payments were made for even a few duplicate claims, there is the risk that duplicate claims for larger amounts could slip through the existing MMIS controls.

Recommendation

8. KHPA should work with its fiscal agent to find out why Edit 5014 (Suspect Duplicate-Pharmacy) and Edit 5015 (Exact Duplicates-Pharmacy) failed to stop some duplicate claims, and should implement appropriate corrective action. We also recommend KHPA initiate recoupment of roughly $1,785 in identified duplicate or suspect duplicate payments.

V. Does KHPA's System of Controls Prevent Payment of Prescription Narcotic Drugs Potentially Intended for Inappropriate Use or Resale?

Prescription drug abuse is the most rapidly increasing form of substance abuse.[39] Drug diversion is becoming a major problem as more individuals abuse prescription drugs or illegally sell drugs on the street. Commonly abused prescription drugs include:

- Opioids (e.g. OxyContin, Darvon, Vicodin, Demerol)
- Central Nervous System Depressants (e.g. Valium, Librium, Xanax)
- Stimulants (Ritalin, Meridia)

Prescription drugs consumed inappropriately or at unsafe levels can pose a serious risk to patients, especially children. Medicaid payment controls do not provide an absolute guarantee against this type of risk because consumers may pay for drugs personally or use alternative insurance. However, payment controls can help diminish the risk by denying payment for certain drugs that may be dangerous at given quantities. For this reason, the Drug Utilization Review Board makes recommendations regarding controls that encourage safer and more cost effective medication use. The Board reviews drugs for the various populations to determine effectiveness, potential dangers, problems with drug interaction and other issues. KHPA then incorporates prepayment controls into its system edits which are reviewed based on changes in prescribing practices and FDA guidance, among others. Edits include those which identify and deny claims for age-inappropriate National Drug Codes (NDCs).

In this audit, the OIG looked at controls designed to address excessive use of oxycodone and beneficiary behavior indicating doctor and pharmacy hopping. We also reviewed KHPA's process for identifying beneficiaries for possible lock-in, as well as KHPA's use of DEA numbers to authenticate prescribers and prevent potential abusers from falsifying prescriber information to acquire narcotic drugs.

Oxycodone

Oxycodone is an opiate used in pain management. It is marketed under different brand names, the most common of which are OxyContin, Percocet and Endocet. As a narcotic with a high potential for abuse, it is categorized by the Food and Drug Administration (FDA) as a Schedule II drug. [40]

The Pharmacy program has installed a system edit that limits the amount of OxyContin a consumer may receive through Medicaid in one month to 14,400 milligrams. Payment is denied

[39] "Know the Facts about Prescription Drug Abuse," Oregon Board of Pharmacy publication, issued Jan. 2007, p. 1

[40] See Appendix D for more information on Schedule II drugs.

for quantities exceeding the limit unless the beneficiary has prior authorization. Slow-release oxycodone poses great danger when taken in large quantities, especially to people who have not developed a tolerance for it. The FDA's medication guide, issued for those who might want or need to use oxycodone, gives the following warning regarding OxyContin:

> OxyContin 60 mg, 80 mg, and 160 mg tablets, a single dose greater than 40 mg, or a total daily dose greater than 80 mg <u>are only for use in opioid-tolerant patients,</u> as they may cause fatal respiratory depression when administered to patients who are not tolerant to the respiratory-depressant or sedating effects of opioids.[41]

News media outlets reported cases of deaths involving OxyContin overdose. For example, CBS News reported in 2002 the death of a 14 year-old girl who took 480 mg of OxyContin.[42] The Gresham Outlook, a news outlet in Oregon, reported the death of an 18-year old high school student in 2009 after she ingested some or all of the six 30 mg tablets of OxyContin pills she bought on the street.[43]

Opioid-tolerant users can take higher dosages of slow-release oxycodone without risking respiratory depression. Since what can be considered a dangerous dosage level depends on the consumer's tolerance, the DUR Board did not recommend 80 mg per day as a daily dosage limit for beneficiaries needing slow-release oxycodone. They did, however, recommend a limit of 14,400 mg per month (which is equivalent to 480 mg per day), which is currently implemented in the system.

We analyzed oxycodone prescription claims paid during the audit period to see if levels exceeding 480 mg per day were prescribed for Medicaid consumers and found 61 such claims totaling $46,917. There is no edit in the MMIS that denies claims for prescriptions based on daily dosage levels, whether or not the consumer has a tolerance for the drug.

There are other narcotics, such as hydromorphone (Dilaudid®) or meperidine (Demerol®), which have similar physiological effects on the human body as oxycodone. Like OxyContin, the pharmacy program regulates the amount that can be dispensed in one month for each of these drugs. For example, no more than 36,000 mg of meperidine or more than 1,440 mg of hydromorphone can be dispensed for one consumer in one month. However, as a way to obtain as many narcotics as possible, abusers could, hypothetically, obtain the allowable maximum amount of OxyContin, the maximum amount of meperidine, and the maximum amount of hydromorphone in one month. We did not find any payment controls or edits that guard against this behavior.

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[41] http://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022272lbl.pdf [Accessed July 9, 2010].
[42] http://www.cbsnews.com/stories/2001/12/12/48hours/main321066.shtml. [Accessed July 9, 2010]
[43] http://www.theoutlookonline.com/news/story.php?story_id=123613294444316500. [Accessed July 14, 2010]

Part of the control environment for preventing narcotic abuse is the prescribing physician and the pharmacy. However, pharmacies cannot detect if a patient already has an identical prescription from another pharmacy and is doctor-hopping. Prescribing physicians may not know if a patient was prescribed the same or similar drugs from another prescriber.

The Kansas Legislature has enacted a statute requiring the Kansas State Board of Pharmacy to establish a Prescription Monitoring Program (PMP).[44] The goal of the PMP is to monitor scheduled substances and drugs of concern dispensed in Kansas or dispensed to an address in Kansas. This should enable pharmacies and prescribers to track utilization of controlled substances by Kansas citizens, making it more difficult for abusers to switch between different narcotics as a way to evade detection. Implementation of this program is set for February 2011.

Prior authorization (PA) is another payment control which helps ensure appropriate use of selected prescription drugs. It is designed to prevent beneficiaries from acquiring more drugs than they need for medical purposes or using certain drugs that may not be the best choice for their health condition. The Pharmacy program requires that for medically necessary conditions which require more than the maximum approved dosage of narcotics such as OxyContin or tramadol, the dose may be approved through the PA process. In these cases, claims must be supported with documentation in the beneficiary's medical records.

Prior authorization also helps in controlling costs by encouraging the use of generic drugs. If a prescriber orders a branded drug when a clinically equivalent generic drug exists and the pharmacy provider needs to be reimbursed at the normal brand rate, then a PA may be requested.

Prescription drugs not on the Preferred Drug List[45] (PDL) may also require prior authorization to reduce off-label drug use determined inappropriate by the State's DUR Board. Reasons justifying the use of a drug through PA are established by the DUR Board and must be provided by the prescribing physician before the drug can be dispensed to a beneficiary. PA criteria are reviewed and approved by the DUR Board.

Lock-In Program

"Doctor-hopping" or "pharmacy-hopping" are terms used to describe drug addicts or abusers' behavior of using several doctors or several pharmacies to obtain habit-forming drugs. These individuals obtain more narcotic drugs than they need for medical purposes either to satisfy their

[44] K.S.A. 65 – 1683.

[45] The PDL is a list of drugs in the same therapeutical class from which prescribers can choose for a particular medical condition. The PDL promotes clinically appropriate utilization of pharmaceuticals in a cost-effective manner.

dependency or to sell the drugs on the black market. An 80 mg OxyContin tablet, for example, costs about $6 at a pharmacy but can sell for up to $80 on the street.[46]

The Pharmacy program has controls that attempt to identify narcotics abusers and manage the filling of their prescriptions. One such control is the lock-in program. In Kansas Medicaid, fiscal agent SURS staff conducts beneficiary reviews to determine whether lock-in is required. Beneficiaries determined to be inappropriately using their medical card are restricted to assigned "lock-in" medical providers for an initial probationary period of two years, with possible extension if the beneficiary continues to misuse services. Standard assignments for lock-in beneficiaries are a physician and pharmacy. If emergency room or outpatient services have been used inappropriately, lock-in assignment includes a hospital.

Direct lock-in can be initiated without a beneficiary review when confirmed abuse has been identified. Beneficiaries have a right to appeal any restrictions with which they may disagree. The fiscal agent's SURS team also uses the Multiple Prescriber or Multiple Pharmacy reports to identify consumers for lock-in. The Multiple Prescriber Report identifies consumers who obtain prescriptions from three or more prescribers per month and the Multiple Pharmacy Report identifies consumers who fill prescriptions at three or more pharmacies per month. On some occasions, consumers can be referred for the lock-in program as a result of a review initiated by the Threshold report. The Threshold Report, which is used mostly for therapeutic management, identifies consumers who received 15 or more drug classes or GCNs (Generic Code Numbers) in one month.[47]

Consumers flagged by the reports are not automatically placed in the lock-in program. Those who are flagged more than once on either the Multiple Prescriber or Multiple Pharmacy report are reviewed to determine whether they are abusing prescription drugs. Depending on the review findings and the severity of their abusive behavior, they are either just counseled or placed in lock-in for two years. In CY 2007 through 2009, 22, 55 and 69 beneficiaries, respectively, were placed in the lock-in program.

Three months before the end of the lock-in program, fiscal agent SURS staff conducts a review to determine whether or not the beneficiary's behavior regarding use of prescription medicine improved. If improvement is noted, the beneficiary is removed from the program; otherwise he or she is placed on extended lock-in.[48] SURS staff conducts another review six to 12 months after a beneficiary is removed from lock-in as a means to monitor behavior.

[46] Pillar, K (April 2004) Drug Abuse in America – Prescription Drug Diversion, The Council of State Governments, April 2004, p. 4
[47] The threshold of 15 or more GCNs per month is set by the Drug Utilization Review Board.
[48] Extended lock-in is when a consumer will be in the program for as long as he/she is eligible and is on Medicaid.

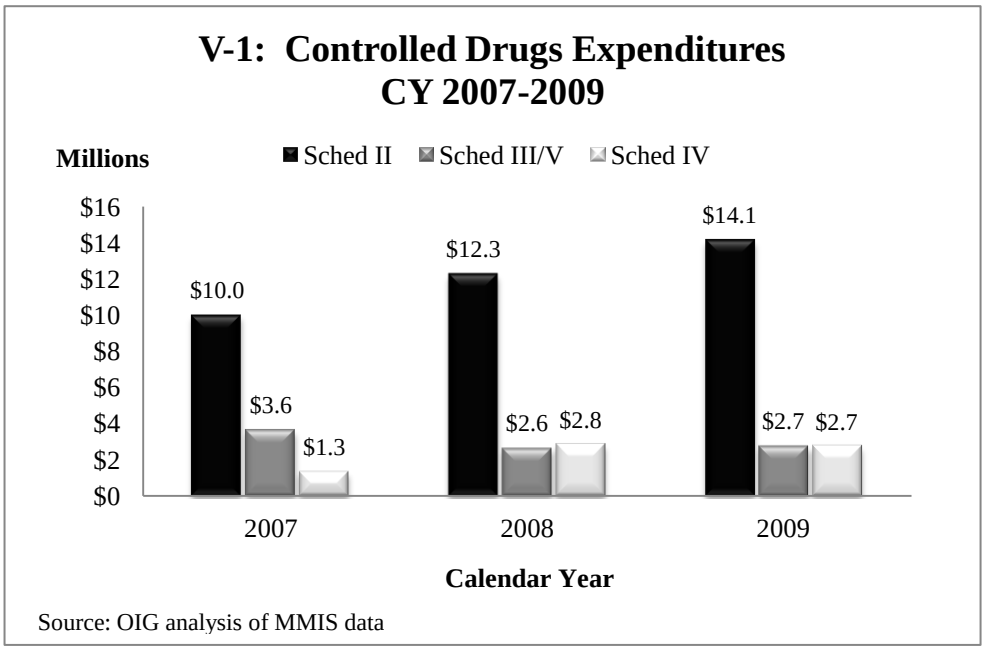
Lock-in assignments are allowed to expire when a utilization review determines the beneficiary has appropriately used his or her medical benefits. Lock-in assignments can be terminated without a utilization review if direction is received from the Office of Administrative Hearings or authorized KHPA personnel.

DEA Registration Requirement for Controlled Drugs

The Code of Federal Regulations has strict requirements regarding information that must be contained on a prescription for a controlled substance.[49] In addition to other information such as the name and address of the prescriber, the regulations require the Drug Enforcement Administration (DEA) registration number of the prescriber to be included on every prescription.[50] The DEA issues registration numbers to professionals authorized to prescribe or handle controlled substances. Each number's authenticity can be verified by using a simple algorithm.

KHPA does not require a controlled substance prescription claim submitted for payment to include the DEA number of the prescriber. It requires only the prescriber's National Provider Identifier (NPI).[51] At some point before April 2008, a system edit was installed in the MMIS to identify controlled substance prescription claims ordered by prescribers without a DEA number. The system edit was designed to pay and list,[52] but became redundant or impractical when KHPA stopped capturing the DEA number upon the directive of the Drug Enforcement Administration. The Pharmacy program makes significant claim payments for controlled substances, as illustrated in the bar graph V-1.

[49] See Appendix D for more information on controlled drug descriptions and examples.
[50] Code of Federal Regulations **21 CFR 1306.05[a]**
[51] It must be noted that MMIS does not verify that an NPI number actually belongs to the person claiming it. All it does is verify that it passes the Luhn test, which is a simple checksum formula for validating identification numbers. The Luhn test was designed to protect against accidental errors, not malicious intentions.
[52] Pay and list is when a claim is paid but the system flags it for post-payment review by KHPA staff.



It must be noted that the Kansas State Board of Pharmacy requires pharmacies to fill a controlled substance prescription only if the prescriber's DEA number is written on the front of the prescription. If not, the pharmacy is not supposed to dispense the drug. We did not conduct a file review of prescriptions to verify that pharmacies are following this policy. However, the Board of Pharmacy audits all pharmacies annually. Among other things, Board investigators verify that prescriptions for controlled substances have DEA numbers on them. Unless they have some reason to doubt the authenticity of a prescription, Board investigators do not routinely check the validity of DEA numbers.

KHPA processed some claims for controlled substance prescriptions with invalid DEA numbers. KHPA collected prescribers' DEA registration numbers prior to NPI implementation in 2008. The OIG tested the validity of these DEA numbers by using the DEA authentication algorithm. Our testwork found 107 invalid DEA numbers for 3,768 claims totaling $531,124 submitted by 261 pharmacies. If a DEA number is invalid, it is unlikely to have been issued by the DEA, the prescriber probably has no authority to order controlled substance prescriptions, and the claim payment is probably improper.

Efforts to transition to electronic prescriptions, which have the potential for performing electronic verification and employing audit software for review are ongoing. The DEA Interim Final Rule on electronic prescriptions scheduled to go into effect June 1, 2010, subject to Congressional review, would allow prescribers the option to write prescriptions for controlled substances electronically, and allow pharmacies to receive, dispense and archive these electronic

prescriptions. The regulations have the potential to reduce prescription forgery and reduce the number of prescription errors.[53]

Conclusion: There is currently no system edit designed to regulate the daily dosage limit of slow-release oxycodone to a level that the Food and Drug Administration advises as safe for consumers. Furthermore, the Medicaid Pharmacy Program does not have an effective edit to ensure drugs in the controlled classes are ordered by prescribers registered with the Drug Enforcement Administration.

Recommendations

9. KHPA should work with its fiscal agent and the Drug Utilization Review board to implement a new edit in the system that will deny a claim with a dosage of OxyContin (or any other slow-release oxycodone drugs) that exceeds a daily threshold without prior authorization.

10. KHPA should work with its fiscal agent and the Drug Enforcement Administration to load and maintain DEA registration numbers in the MMIS. Until that can be accomplished, KHPA should review random samples of controlled substance prescriptions periodically. The review should include verifying the DEA number on the claim is current, valid and belongs to the individual who ordered the prescription.

[53] Kansas State Board of Pharmacy newsletter, September 2010, "DEA releases e-Prescription for Controlled Substances Interim Final Rule, p. 2

Appendix A: Agency Response

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KANSAS HEALTH POLICY AUTHORITY

October 29, 2010

Nick Kramer
Inspector General
Kansas Health Policy Authority
109 S.W. 9th Street, 7th Floor
Topeka, KS 66612-1280

Dear Mr. Kramer:

The Kansas Health Policy Authority (KHPA) has received the Office of the Inspector General's (OIG) report regarding its audit of KHPA's pharmacy program's system of controls designed to prevent improper pharmacy payment and appreciates the opportunity to respond to the report. KHPA is pleased that the audit findings revealed no systematic problems warranting significant and immediate action.

KHPA Comments on OIG Conclusions and Recommendations

Prevention of payment of claims for drugs allegedly dispensed for deceased beneficiaries

Conclusion: *KHPA incurs minimal loss of funds due to paying for prescription drugs for deceased beneficiaries. KHPA's post-payment death audits appear to be reasonably effective in identifying overpayments related to drugs allegedly dispensed for deceased beneficiaries. However, it is essential that beneficiary death dates are promptly and accurately updated to minimize overpayments and control the risk of unauthorized individuals obtaining fraudulent payments or drugs using the identification number of a deceased beneficiary.*

A reasonable amount of time lag in updating beneficiary death dates in KAECSES, and therefore in MMIS, is expected. However, KHPA could gain some efficiency by loading death data directly from an official government source such as the Social Security Administration. While this will not prevent claims from being paid after beneficiaries die, it increases the probability that death dates are updated in MMIS, ensures that pharmacy claims paid after beneficiaries die are flagged in the annual death date audits, and could reduce amounts to be recovered through pay and chase.

Recommendation:

1. KHPA should update KAECSES/MMIS death dates promptly and accurately using KDHE Vital Statistics death data or the Social Security death database.

KHPA's response:
KHPA agrees that prompt and accurate maintenance of beneficiary dates of death is important to prevent potential overpayments for deceased beneficiaries. All beneficiary eligibility information is fed into the MMIS

through KAECSES, the system of record for beneficiary information; no beneficiary information is inputted directly into the MMIS. Maintenance of KAECSES is a function of SRS, and any interface with KDHE or the SSA would have to be between SRS and that agency. SRS currently receives a feed from KDHE which, as described in the audit report, is then distributed to eligibility workers for verification before inputting the date of death provided by KDHE into KAECSES. We believe the involvement of the eligibility worker is prudent given that 24 of the 37 beneficiaries originally identified by the OIG auditors as being deceased according to KDHE files, were actually still living. The demonstrated risk of denying claims for living beneficiaries without the eligibility worker double-check would create unnecessary access-to-care issues. We have not assessed the validity of data available from the SSA but agree that a direct linkage with SSA records holds the promise of a simpler and more accurate source of information. KHPA will share the OIG's recommendation with SRS and will evaluate the use of SSA death records in the design and implementation of the new K-MED eligibility system scheduled for completion in 2013. For the claims identified in this report, KHPA will work the fiscal agent to recoup those claims for which payment was inappropriate.

Assurance that prescribers in pharmacy claims are authorized and licensed

Conclusion: *The vast majority of prescriptions for Kansas Medicaid beneficiaries are ordered by KMAP-enrolled prescribers. For these prescribers, KHPA has controls in place to validate their identity and determine whether their provider types are allowed to prescribe.*

However, KHPA's current practice allows for paying some claims where the prescriber's identity and authority to prescribe cannot be verified, such as the case with out-of-state or non-KMAP-enrolled prescribers. In addition, while KHPA requires a copy of a renewed license upon license expiration of billing providers, it does not have similar procedures to validate that prescribers, whether KMAP-enrolled or non-KMAP-enrolled, have valid and current licenses and are in good standing with their licensing board when they order a prescription. KHPA should either revise its policy to deny payment for prescriptions ordered by prescribers whose identity, license and authority to prescribe cannot be verified or adopt alternative approaches to verify prescribers.

Recommendations:

2. KHPA should utilize CMS' NPPES or NPI Registry for non-Kansas Medicaid enrolled providers and make sure NPI and name match to help authenticate the identity of the prescribers.

KHPA's response:
KHPA will institute on January 1, 2011 the PPACA provision requiring that all ordering or referring providers be enrolled as a Medicaid provider, which we expect will greatly mitigate this issue. The OIG's recommendation to verify the name of the prescriber to the NPI using the NPPES database poses operational challenges. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that all pharmacy claims be submitted using the National Council for Prescription Drug Plans (NCPDP) transaction standard (current version 5.1). The NCPDP standard does have a field that could accept prescriber last name (field 427-DR), however the field has a 15 character limitation. Any name with more than 15 characters (such as a hyphenated name) would deny inappropriately with that check in place. Also, the added verification between the submitted NPI and the NPPES would lengthen the processing time for pharmacy claims, potentially

impacting the "real-time" pharmacy processing claim requirements of HIPPA due to the size and use of the data base. The January, 2010 NPPES database contained more than three million unique providers and an average of fifteen to twenty thousand point of sale pharmacy claims are submitted daily.

3. KHPA should use healthcare licensing boards' licensing data to ensure only claims for prescriptions ordered by prescribers in good standing with their licensing boards are paid. To implement this practice, KHPA management should consider the following options:
    a. Deny claims when the license status of the prescriber ordering the prescription cannot be verified.
    b. Obtain healthcare licensing data from surrounding states where Kansas Medicaid beneficiaries obtain prescriptions.
    c. Require all prescribers to enroll in Kansas Medicaid and deny claims for those prescribers whose license status is not in good standing with their licensing board.

KHPA's response:
KHPA agrees that only prescriptions written by prescribers in good standing with their licensure boards should be paid but disagrees with the methodology recommended to achieve this assurance. A review of the licensing data has revealed a lack of reliability for use as prescriber validation prior to point-of-sale claim payment. KHPA pharmacy staff examined licensure data provided by KBOHA and found inconsistencies with the prescriber's true license status. Comprehensive validation with licensure records would require the development of interfaces with the Kansas Board of Healing Arts, the Kansas Dental Board, the Kansas Board of Examiners in Optometry, and the Kansas Board of Nursing, and also between the corresponding licensing agencies in neighboring states Missouri, Colorado, Oklahoma, and Nebraska. Inter-state communication would be particularly important for Missouri, since one of Kansas' two major metropolitan areas spans the Missouri/Kansas borders. The effort to establish and maintain these interfaces would be costly and require regular updating. Implementation of the PPACA requirement for enrollment of all prescribers in the Medicaid program will ensure that all prescriber's licenses are valid at the time of enrollment and KHPA will work with the various licensing entities in Kansas and surrounding states to explore ways to improve the reliability of the licensure data so in the future it could be used to validate the current licensure standing of prescribers.

4. KHPA should review its policy for allowing prescriptions to be refilled up to one year after the prescription was originally issued. The policy is in compliance with current law, but it conflicts with the recent June 2010 Board of Pharmacy advisory on the one-time validity of prescriptions which have lost their legitimate medical purpose due to the death, retirement or relocation of the prescribing physician.

KHPA's response:
KHPA has reviewed its current policy and believes it to be consistent with state law and oversight provided by the Board of Pharmacy. Board of Pharmacy Regulation 68-2-20 obligates a pharmacist to ensure a prescription for a drug was issued with a valid preexisting patient-prescriber relationship. Determining the validity of a prescription therefore falls under the purview of the Board of Pharmacy.

Current claims payment policy follows the statutory definition of prescription validity, as outlined in K.S.A. 65-1637.

5. KHPA should utilize KDHE's death data or the Social Security Administration's death database to promptly and accurately deny claims for prescriptions allegedly ordered by deceased prescribers. KHPA SURS staff should review exceptions and refer to MFCU, if records indicate fraud.

KHPA's response:
KHPA agrees with this recommendation. Payment for prescriptions written by deceased prescribers, particularly those filled greater than a year after the prescriber's date of death, is inappropriate. KHPA recognizes the potential usefulness of provider death information and has already begun working on an agreement with KDHE to obtain that information on a regular basis. As with the use of KDHE death records to prevent dispensation of drugs to deceased beneficiaries, use of KDHE's date of death information in the claims payment process requires validation.

Assurance that only currently licensed pharmacies dispense prescription drugs and receive Medicaid payments

Conclusion: *KHPA's provider enrollment and licensing controls, together with Board of Pharmacy requirements, help minimize the likelihood that pharmacies can dispense drugs and obtain Medicaid payments after their licenses expire. However, the OIG noted one instance during the audit period where claims were paid for drugs dispensed after a pharmacy's license expired and one instance where claims were paid for drugs dispensed after a pharmacy's KMAP termination date.*

Recommendations:

6. KHPA should work with its fiscal agent to improve controls to ensure that no payments are made to pharmacies for drugs dispensed after expiration of the pharmacy's license. KHPA should also consider initiating recoupment action on the $11,012 paid for prescriptions filled during the period following the pharmacy's termination from Medicaid for failure to maintain a license.

KHPA's response:
KHPA agrees with this recommendation

7. KHPA should formulate a clear policy regarding the termination effective date in situations where providers request retroactive termination and there are claims paid for prescriptions filled beyond the date being requested. In addition, KHPA should review the pharmacy identified by OIG as having been terminated retroactively and determine whether to initiate recoupment of the $242,232 paid for claims filled beyond the termination effective date.

KHPA's response:
KHPA agrees with this recommendation and has already developed and implemented processes to eliminate such occurrences. In the past, when a provider number was inactivated/terminated with a retroactive date, the Provider Enrollment (PE) team did not verify if claims had been paid for dates after the requested end date,

creating the appearance that a few providers had been paid for services after the provider number was inactivated. However, when the claims were submitted for processing, the provider numbers were still active; therefore, the claims were processed and paid appropriately. The end date was entered after the claims were processed and artificially created the appearance of a processing error. In mid 2008, a new Program Manager was given oversight of Provider Enrollment and instructed the team not to establish a retroactive termination date if there were paid claims with dates of service following that termination date. As a result of the new leadership, if there are paid claims, the claims will either be recouped or adjusted or the end date will be made after the date of service of the latest paid claim.

Prevention of duplicate prescription drug claims

Conclusion: *The OIG analysis indicated that KHPA paid very few duplicate claims during the audit period. However, because payments were made for even a few duplicate claims, there is the risk that duplicate claims for larger amounts could slip through the existing MMIS controls.*

Recommendation:

8. KHPA should work with its fiscal agent to find out why Edit 5014 (Suspect Duplicate-Pharmacy) and Edit 5015 (Exact Duplicates-Pharmacy) failed to stop some duplicate claims, and should implement appropriate corrective action. We also recommend KHPA initiate recoupment of roughly $1,785 in identified duplicate or suspect duplicate payments.

KHPA's response:
KHPA agrees with this recommendation. In response to initial communication by OIG staff, a sample of duplicate claims was provided to HP systems staff for resolution. The HP systems team researched and discovered intermittent duplicate claim payment caused by a time-out issue on reversed claims. As documented in CSR 12957, which was implemented on 10/22/2010, claims from October 2003 to present were examined; 189 claims were identified for a total paid amount of $11,609.36. These overpayments will be recouped.

Prevention of payment of prescription narcotic drugs potentially intended for inappropriate use or resale

Conclusion: *There is currently no system edit designed to regulate the daily dosage limit of slow-release oxycodone to a level that the Food and Drug Administration advises as safe for consumers. Furthermore, the Medicaid Pharmacy Program does not have an effective edit to ensure drugs in the controlled classes are ordered by prescribers registered with the Drug Enforcement Administration.*

Recommendations:

9. KHPA should work with its fiscal agent and the Drug Utilization Review board to implement a new edit in the system that will deny a claim with a dosage of OxyContin (or any other slow-release oxycodone drugs) that exceeds a daily threshold without prior authorization.

KHPA's response:
KHPA agrees with the recommendation to implement dosage controls for OxyContin, but believes that recent policy adoption by the DUR Board will address the identified potential for the overuse. In April 2010 the DUR

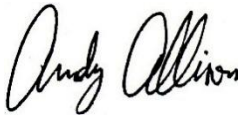
Board approved new limitations for both short-acting and long acting narcotics. Policies E2010-058, E2010-059, and E2010-064 document these limitations. Policy E2010-64 includes a quantity (i.e. tablet/capsule) per day limitation on OxyContin, as well as other long-acting opioids. After implementation, beneficiaries will be unable to obtain without prior authorization more than three units per day of any one strength of OxyContin, (except the highest strength), and no more than six units per day of any combination of strengths (including the highest strength). These edits will ensure use of OxyContin as indicated by the drug's package insert, and will result in daily dosage limitations significantly below the OIG recommended threshold of 480mg in many cases (i.e. 30mg per day maximum for 10mg tablets, 60mg per day maximum for 20mg tablets, etc.).

10. KHPA should work with its fiscal agent and the Drug Enforcement Administration to load and maintain DEA registration numbers in the MMIS. Until that can be accomplished, KHPA should review random samples of controlled substance prescriptions periodically. The review should include verifying the DEA number on the claim is current, valid and belongs to the individual who ordered the prescription.

KHPA's response:
KHPA that verification that the prescribing provider of a controlled substance has a current, valid DEA number would strengthen our oversight of the claims processing of controlled classes of drugs. Protection against invalid DEA numbers is currently offered at the point of sale. Regulation 68-20-18 requires pharmacists to verify the validity of a prescription for a controlled substance, including the DEA registration number of the prescriber. If the prescriber has no authority to prescribe a controlled substance, the dispensing pharmacist is legally required to refuse to fill that prescription. Verification of the DEA number within the MMIS does not appear to be feasible at this time. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that all pharmacy claims use the NCPDP 5.1 transaction standard, which allows for submission of only one prescriber identifier. Submission of both the NPI and DEA number is not possible and currently pharmacy claims are submitted using the NPI, as stipulated by federal law. KHPA is hopeful that access to the DEA Registry will become available, facilitating DEA number verification.

We appreciate the efforts of the OIG staff in conducting the audit and being willing to discuss early drafts of the audit. Thank you for the opportunity to respond to the draft audit report.

Sincerely,



Andrew Allison, PhD
Executive Director

cc: Dr Barbara Langner, Medicaid Director
LeAnn Bell, Senior Manager Medicaid Pharmacy Unit

Appendix B: Acronyms

ARRA	American Recovery and Reinvestment Act of 2009
CMS	Centers for Medicare and Medicaid Services
CSA	Controlled Substances Act of 1970
CY	Calendar Year
DEA	Drug Enforcement Administration
DRA	Deficit Reduction Act
DUR	Drug Utilization Review
FDA	Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee-for-Service
FY	State Fiscal Year
HIE	Health Information Exchange
HIT	Health Information Technology
KAECSES	Kansas Automated Eligibility and Child Support Enforcement System
KDHE	Kansas Department of Health and Environment
KHPA	Kansas Health Policy Authority
KMAP	Kansas Medical Assistance Program
K.S.A.	Kansas Statute Annotated
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MMIS	Medicaid Management Information System
NDC	National Drug Code
NPI	National Provider Identifier
OIG	Office of Inspector General
PA	Prior Authorization
PDL	Preferred Drug List
PMP	Prescription Drug Monitoring Program
SAS-70	Statement on Auditing Standards 70
SGF	State General Fund
SURS	Surveillance and Utilization Review Subsystem

Appendix C: SURS Provider Reviews

SURS Provider Reviews

SURS staff opened and reviewed 18 pharmacy cases in CY 2008 and 21 pharmacy cases in CY 2009. Pharmacy provider reviews include a comparison of prescriptions and claims. These reviews are separate from SURS' death date audits and related provider reviews.

Example of a related provider review. SURS staff initiates a review of Doctor A's billing. Staff may observe that a beneficiary is obtaining a large number of prescriptions for Suboxone. In reviewing where the beneficiary is having these prescriptions filled, staff may find that Pharmacy B overrode early refill alerts for the beneficiary on a regular basis. Staff may then request records from Pharmacy B to assure the early refills were approved by Doctor A. If staff found there is no documentation to indicate Doctor A approved the early refills, staff would identify claims for those early refills for recoupment. The recoupment from Pharmacy B is considered a related provider recoupment.

For pharmacy review cases closed in CY 2007 to CY 2009, SURS staff identified $164,574, $297,363 and $252,482 in overpayments, respectively. Overpayments identified in CY 2007 and CY 2008 were primarily for services that exceeded pharmacy program limitations – pharmacy services that did not fall within guidelines for pharmacy benefits and limitations. Overpayments identified in CY 2009 were primarily for pharmacy services that exceeded program limitations and those with no documentation to support the services billed and reimbursed. Cases opened in CY 2007 to CY 2009 for SURS review and cases closed during the same time period may not be the same. Some cases may go through the appeals process and take a while to close.

According to SURS staff, they have referred pharmacy cases for fraud – one pharmacy in 1999; one pharmacy in 2003; two pharmacies in 2006, one of which was the same pharmacy referred in 2003; and, one pharmacy in 2008.

Appendix D: Controlled Substances by CSA Schedule

Controlled Substances by CSA[(a)] Schedule		
CSA Schedule	**Description**	**Examples**
I	High potential for abuse Not currently accepted for medical use Not considered safe	Ecstasy, Heroin, LSD, Marijuana
II	High potential for abuse Accepted for medical use Abuse may lead to severe dependence	Cocaine, Methadone, OxyContin, Percocet
III	Potential for abuse less than schedules I & II Accepted for medical use Abuse may lead to moderate or low physical or high psychological dependence	Lorcet, Vicodin, Lortab, anabolic steroids
IV	Low potential for abuse relative to schedule III Accepted for medical use Abuse may lead to limited dependence relative to schedule III	Xanax, Valium, Klonopin, Ativan
V	Low potential for abuse relative to schedule IV Accepted for medical use Abuse may lead to limited dependence relative to schedule IV	Robitussin A-C, Motofen, Kapectolin PG

[(a)] Controlled Substances Act of 1970

Source: The Council of State Governments, Drug Abuse in America - Prescription Drug Diversion Report, April 2004

Appendix E: Relevant State Regulations and Statutes

K.S.A. 21-3846	False claims in Medicaid and types of felonies and misdemeanors
K.S.A. 21-3851	Penalties for Medicaid fraud; payment of restitution
K.S.A. 39-7,118	Mandates the creation of the DUR program and the DUR Board
K.S.A. 39-7, 119	Describes the DUR Board requirements and responsibilities
K.S.A. 39-7, 120	Describes limitations on restrictions of patient access to prescription-only drugs through prior authorization or restrictive formulary.
K.S.A. 39-7, 121	Requires KHPA have an electronic claims management system that provides on-line adjudication of claims and ProDUR alerts. This system may not be used to require step therapy.
K.S.A 39-7, 121a	Gives KHPA the authority to create a PDL committee and a PDL.
K.S.A. 39-7, 121b	Prohibits the restriction in any way of drugs used to treat mental illness.
K.S.A. 39-7, 121c	Pertains to certain medication not subject to Prior Authorization
K.S.A. 39-7, 121d	Allows a different dispensing fee for pharmacies that service adult care homes, which dispense drugs in a unit dose system and who participate in the return of unused medications program.
K.S.A. 39-7, 121e	States that KHPA may limit reimbursement for a prescription under the KMAP to the multisource generic equivalent drug.
K.S.A. 65-1626a	Practice of pharmacy defined; persons engaged
K.S.A. 65-1627	Grounds for revocation, suspension, placement in probationary status, denial, temporary suspension or temporary limitation of license for pharmacist
K.S.A. 65-1631	Licensure required of pharmacists; qualification of applicants; application for licensure by examination
K.S.A. 65-1636	Sale of drugs limited to pharmacies
K.S.A. 65-1637	Pharmacist required to be in charge of pharmacy; compounding, filling and refilling of prescriptions
K.S.A. 65-1642	Equipment of pharmacy; records of prescription orders; electronic transmission of prescription drug orders
K.S.A. 65-1643	Registration or permit required; pharmacies, manufacturers, wholesalers, auctions, sales, distribution or dispensing of samples, retailers
K.S.A. 65-1645	Applications for registrations and permits; renewals; forms; fees
K.S.A. 65-1656	Filling transferred prescriptions; exceptions and conditions; rules and regulations
K.S.A. 65-1685	Prescription monitoring program database information is privileged and confidential. Information is not subject to the Kansas Open Records Act. Lists entities who may which may have access to data (includes designated representatives of KHPA).
K.S.A. 75-7408	Lists the powers, duties and functions of KHPA
K.S.A. 75-7426	Third party liability under Medicaid
K.S.A. 77-421 (3)	Included are procedures the KMAP must take to establish permanent PA for drugs. It involves a 30 day notification process to the Kansas Register, the Secretary of State, and Joint Committee on Administrative Rules and Regulations.